		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023317

Facility Name: Eldercare of Alton

Address: 3525 Wickenhauser (Number) Alton (City) 62002 (Zip Code)

County: Madison

Telephone Number: 618-465-8887 **Fax #** 618-465-1811

IDPA ID Number: 37-1024089002

Date of Initial License for Current Owners: 04/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: David Read **Telephone Number:** 618-234-2273

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steve Wolf

(Title) Executive Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	138	Skilled (SNF)	138	50,370	1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	187	TOTALS	187	68,255	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	46,143	4,229	2,078	52,450	8
9	SNF/PED					9
10	ICF	7,700	425		8,125	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	53,843	4,654	2,078	60,575	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.75%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 2,078

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	210,161	18,809	12,632	241,602		241,602		241,602			1
2	Food Purchase		229,796		229,796		229,796		229,796			2
3	Housekeeping	202,817	16,995		219,812		219,812		219,812			3
4	Laundry	96,336	10,416	19,519	126,271		126,271		126,271			4
5	Heat and Other Utilities			99,198	99,198		99,198	1,967	101,165			5
6	Maintenance	55,037	21,853	31,115	108,005		108,005	2,807	110,812			6
7	Other (specify):*											7
8	**TOTAL General Services**	564,351	297,869	162,464	1,024,684		1,024,684	4,774	1,029,458			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,622,975	193,734	309,528	2,126,237	(155,946)	1,970,291		1,970,291			10
10a	Therapy	58,057		148,604	206,661	(52,338)	154,323		154,323			10a
11	Activities	62,166	6,798		68,964		68,964		68,964			11
12	Social Services	64,591	93	7,250	71,934		71,934	(725)	71,209			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,807,789	200,625	483,382	2,491,796	(208,284)	2,283,512	(725)	2,282,787			16
	C. General Administration											
17	Administrative	149,536		99,464	249,000		249,000	(99,464)	149,536			17
18	Directors Fees											18
19	Professional Services			4,437	4,437		4,437	7,116	11,553			19
20	Dues, Fees, Subscriptions & Promotions			58,519	58,519		58,519	(30,573)	27,946			20
21	Clerical & General Office Expenses	290,483	20,390	38,545	349,418		349,418	11,043	360,461			21
22	Employee Benefits & Payroll Taxes			347,504	347,504		347,504	30,672	378,176			22
23	Inservice Training & Education			2,143	2,143		2,143		2,143			23
24	Travel and Seminar			11,088	11,088		11,088	915	12,003			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,301	72,301		72,301	334	72,635			26
27	Other (specify):*											27
28	**TOTAL General Administration**	440,019	20,390	634,001	1,094,410		1,094,410	(79,957)	1,014,453			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,812,159	518,884	1,279,847	4,610,890	(208,284)	4,402,606	(75,908)	4,326,698			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Eldercare of Alton #0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			108,686	108,686		108,686	3,349	112,035			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,244	1,244		1,244		1,244			32
33	Real Estate Taxes			85,681	85,681		85,681		85,681			33
34	Rent-Facility & Grounds			531,241	531,241		531,241	7,211	538,452			34
35	Rent-Equipment & Vehicles			329	329		329	3,326	3,655			35
36	Other (specify):*											36
37	**TOTAL Ownership**			727,181	727,181		727,181	13,886	741,067			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					208,284	208,284		208,284			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		13,967		13,967		13,967		13,967			41
42	Provider Participation Fee			102,383	102,383		102,383		102,383			42
43	Other (specify):* **Sales Tax**			2,353	2,353		2,353		2,353			43
44	**TOTAL Special Cost Centers**		13,967	104,736	118,703	208,284	326,987		326,987			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,812,159	532,851	2,111,764	5,456,774		5,456,774	(62,022)	5,394,752			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	190	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(638)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,534)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Attached	(17,829)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (31,811)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(30,211)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (30,211)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (62,022)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39	Therapy	X		52,338	10	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	X		53,947	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule Lab/X-Ray	X		5,347	10	45
46	Other-Attach Schedule Supplies	X		96,652	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 208,284		47

Eldercare of Alton

ID# 0023317

Report Period Beginning: 1/1/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beauty Income	$ (725)	12	1
2	Lobbying	(3,961)	20	2
3	Public Relations	(12,547)	20	3
4	Chamber of Commerce Dues	(596)	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(17,829)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,967	0	0	0	0	0	0	0	0	1,967	5
6	Maintenance	0	0	2,807	0	0	0	0	0	0	0	0	2,807	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	4,774	0	0	0	0	0	0	0	0	4,774	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(725)	0	0	0	0	0	0	0	0	0	0	(725)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(725)	0	0	0	0	0	0	0	0	0	0	(725)	16
	C. General Administration													
17	Administrative	0	0	(99,464)	0	0	0	0	0	0	0	0	(99,464)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	7,116	0	0	0	0	0	0	0	0	7,116	19
20	Fees, Subscriptions & Promotions	(31,276)	0	703	0	0	0	0	0	0	0	0	(30,573)	20
21	Clerical & General Office Expenses	0	0	11,043	0	0	0	0	0	0	0	0	11,043	21
22	Employee Benefits & Payroll Taxes	0	0	30,672	0	0	0	0	0	0	0	0	30,672	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	915	0	0	0	0	0	0	0	0	915	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	334	0	0	0	0	0	0	0	0	334	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(31,276)	0	(48,681)	0	0	0	0	0	0	0	0	(79,957)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,001)	0	(43,907)	0	0	0	0	0	0	0	0	(75,908)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Eldercare of Alton # 0023317 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	190	0	3,159	0	0	0	0	0	0	0	0	3,349	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	7,211	0	0	0	0	0	0	0	0	7,211	34
35	Rent-Equipment & Vehicles	0	0	3,326	0	0	0	0	0	0	0	0	3,326	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	190	0	13,696	0	0	0	0	0	0	0	0	13,886	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(31,811)	0	(30,211)	0	0	0	0	0	0	0	0	(62,022)	45

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Wolf	30	Calvin Johnson Care Center	Belleville	Eldercare Inc	Belleville	Nur Home Mgt
	50	Columbia Convalescent Center	Columbia			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17-1	Home Office Adm Wages	$ 79,563	Eldercare Inc	0.00%	$ 79,563	$	1
2	V		21-1	Home Office Wages	129,923	Eldercare Inc	0.00%	129,923		2
3	V		17-3	Home Office Expenses	99,464	Eldercare Inc	0.00%	69,253	(30,211)	3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 308,950			$ 278,739	$ * (30,211)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Eldercare Inc		$ 1,967	$ 1,967	15
16	V	6	Maintenance		Eldercare Inc		2,807	2,807	16
17	V	17	Officer Salary	79,563	Eldercare Inc		79,563		17
18	V	19	Legal & Acctg		Eldercare Inc		7,116	7,116	18
19	V	20	Dues & Lic		Eldercare Inc		703	703	19
20	V	21	Clerical Sal	129,923	Eldercare Inc		129,923		20
21	V	21	Admin		Eldercare Inc		11,043	11,043	21
22	V	22	Payroll Taxes		Eldercare Inc		30,672	30,672	22
23	V	24	Travel		Eldercare Inc		915	915	23
24	V	26	Ins		Eldercare Inc		334	334	24
25	V	30	Depreciation		Eldercare Inc		3,159	3,159	25
26	V	34	Building Lease		Eldercare Inc		7,211	7,211	26
27	V	35	Equipment Lease		Eldercare Inc		3,326	3,326	27
28	V	17	Home Office Expenses	99,464				(99,464)	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 308,950			$ 278,739	$ * (30,211)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Steve Wolf	President	Executive Admin	30.00	A 259305	17	34.00	Salary	$ 79,563	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9			A Columbia Conv. Ctr 169403								9
10			Calvin Johnson 89902								10
11											11
12											12
13								TOTAL	$ 79,563		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Eldercare Inc.
Street Address: 2620 W. Blvd.
City / State / Zip Code: Belleville, IL. 62221-7208
Phone Number: (618-234-2273
Fax Number: (618-234-7777

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Direct Cost	11,629,339		$ 4,190	$	5,459,906	$ 1,967	1
2	6	Maintenance	Direct Cost	11,629,339		5,980		5,459,906	2,807	2
3	17	Home Office Adm Wages	Direct Cost	11,629,339		169,465	169,465	5,459,906	79,563	3
4	19	Legal & Acctg	Direct Cost	11,629,339		15,156		5,459,906	7,116	4
5	20	Dues & Lic	Direct Cost	11,629,339		1,498		5,459,906	703	5
6	21	Home Office Wages	Direct Cost	11,629,339		276,729	276,729	5,459,906	129,923	6
7	21	Administrative expenses	Direct Cost	11,629,339		23,521		5,459,906	11,043	7
8	22	Payroll Taxes	Direct Cost	11,629,339		65,330		5,459,906	30,672	8
9	24	Travel	Direct Cost	11,629,339		1,948		5,459,906	915	9
10	26	Insurance	Direct Cost	11,629,339		712		5,459,906	334	10
11	30	Depreciation	Direct Cost	11,629,339		6,728		5,459,906	3,159	11
12	34	Building Lease	Direct Cost	11,629,339		15,360		5,459,906	7,211	12
13	35	Equipment Lease	Direct Cost	11,629,339		7,083		5,459,906	3,326	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 593,699	$ 446,194		$ 278,739	25

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2				N/A								2
3												3
4												4
5												5
	Working Capital											
6	AI Credit Corp		X	Insurance Financing	Quarterly	4/1/01	79,215	21,210		0.0787	1,244	6
7												7
8												8
9	TOTAL Facility Related						$ 79,215	$ 21,210			$ 1,244	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 79,215	$ 21,210			$ 1,244	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	81,084	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	82,765	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,681	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	84,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	85,681	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996	80,703	8
1997	84,532	9
1998	80,120	10
1999	80,281	11
2000	82,765	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Eldercare of Alton COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0023317

CONTACT PERSON REGARDING THIS REPORT David Read

TELEPHONE 618-234-2273 FAX #: 618-234-7777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	23-1-08-17-10-105-027	Nursing Home & 4.42 Acres	$ 82,765.14	$ 82,765.14
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 82,765.14	$ 82,765.14

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,621 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories Two

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvemenys			1982	2,080		10			2,080	9
10	Improvemenys			1983	3,330		10			3,330	10
11	Improvemenys			1985	3,728		7			3,728	11
12	Improvemenys			1985	10,578	529	20	529	(0)	8,727	12
13	Improvemenys			1986	5,506		10			5,506	13
14	Heat Range			1988	1,190		10			1,190	14
15	Door Alarm			1991	8,986	449	20	449	0	4,829	15
16	Nurse Station Remodeling			1991	60,801	4,053	15	4,053	0	42,561	16
17	Carpet			1991	1,482		5			1,482	17
18	Asphalet Sealer			1992	2,900	242	12	242	(0)	2,515	18
19	Remodeling			1992	77,249	5,150	15	5,150	(0)	48,924	19
20	Roof & Remodeling			1993	68,700	4,580	15	4,580		37,785	20
21	Remodel Hall & Offices			1994	20,445	1,363	15	1,363		10,828	21
22	Concrete			1994	1,677	112	15	112	(0)	811	22
23	Roof Repairs & Asphalt			1995	2,150	179	12	179	0	1,164	23
24	Waste Line Renovations			1996	15,112	756	20	756	(0)	4,156	24
25	New Therapy Room			1996	3,782	252	15	252	0	1,450	25
26	Awnings			1996	12,500	1,250	10	1,250		6,875	26
27	Sidewalks & Parking Lot Seal			1996	8,930	548	5-15y	738	190	4,006	27
28	Landscape			1996	7,436	744	10	744	(0)	3,904	28
29	Carpet			1997	1,950	390	5	390		1,658	29
30	Concrete Walls & Signs			1997	14,479	965	15	965	0	4,344	30
31	Hall Renovations			1998	3,516	352	10	352	(0)	1,231	31
32	Laundry Boiler			1998	1,241	83	15	83	(0)	331	32
33	Parking Lot			1998	14,062	1,172	12	1,172	(0)	4,102	33
34	Landscape			1998	1,383	138	10	138	0	553	34
35	Drywall,Wall Carpet,Stained Glass Door,Lighting Chapel			1999	20,560	2,056	10	2,056		4,626	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tubesheets & Copper Tubes in Water Heater	1999	$ 6,904	$ 986	7	$ 986	$ 0	$ 2,466	37
38	Drywall,Wall Carpet,Electric Work,and Flooring	2000	23,534	2,353	10	2,353	0	3,530	38
39	Duro-last Roofing System	2000	165,440	16,544	10	16,544		20,680	39
40	Roof-top HVAC Unit & 2 HVAC/Heat Unit-DR&Kitchen	2000	60,000	7,500	8	7,500		9,375	40
41	Foutain, Brick & Keystone install, Bush removal	2000	1,178	118	10	118	(0)	177	41
42	Asphalt Parking Lot	2001	7,745	323	12	323	(0)	323	42
43	Sidewalk entrance	2001	11,061	369	15	369	(0)	369	43
44	PA System	2001	573	57	5	57	0	57	44
45	Rooftop A/C	2001	4,133	258	8	258	0	258	45
46	Fireplace Dining Room/Awning	2001	3,917	196	10	196	(0)	196	46
47	New lighting-all wings/handrails	2001	49,081	1,636	15	1,636	0	1,636	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 709,319	$ 55,703		$ 55,893	$ 190	$ 251,763	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 486,983	$ 48,748	$ 48,748	$	5-20yr	$ 208,155	71
72	Current Year Purchases	57,895	4,235	4,235		5-15yr	4,235	72
73	Fully Depreciated Assets	77,837					77,837	73
74	H.O. Depr			3,159	3,159			74
75	TOTALS	$ 622,715	$ 52,983	$ 56,142	$ 3,159		$ 290,227	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1985 Van		$ 10,041	$	$	$		$ 10,041	76
77	Patient Transportation	1991 Bus		39,855					39,855	77
78										78
79										79
80	TOTALS			$ 49,896	$	$	$		$ 49,896	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,381,930	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 108,686	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 112,035	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,349	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 591,886	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Vending Machine 1980	$ 4,584	$	$ 4,584	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 4,584	$	$ 4,584	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: National Nursing Home, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1971	187	04/01/77	$ 531,241	20	20	3
4	Additions							4
5	H.O. Lease				7,211			5
6								6
7	TOTAL		187		$ 538,452 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning 04/01/97
Ending 04/01/02

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ CPI index increase
13.	/2003	$ CPI index increase
14.	/2004	$ CPI index increase

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,706 Description: Office & H.O. Equip Lease
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	537	$ 33,825	$	537	$ 33,825	1
2	Licensed Speech and Language Development Therapist		hrs		62	4,470		62	4,470	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		188	14,043		188	14,043	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				53,947		53,947	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Supplies Other (specify): Lab,X-Ray,& Amb						96,652 5,347		96,652 5,347	13
14	TOTAL			$	787	$ 52,338	$ 155,946	787	$ 208,284	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 99,751	$	1
2	Cash-Patient Deposits	29,681		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,819,326		3
4	Supply Inventory (priced at Cost)	33,768		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,242		6
7	Other Prepaid Expenses	45,976		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,081,744	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	709,319		15
16	Equipment, at Historical Cost	672,611		16
17	Accumulated Depreciation (book methods)	(591,611)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 790,319	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,872,063	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 192,626	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,681		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,516		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,782		31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	21,210		36
37	Interfacility Payable	(741,912)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (276,097)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (276,097)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,148,160	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,872,063	$	48

***(See instructions.)**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,076,382	1
2	Restatements (describe):		2
3	**Adjust Income Tax 2000**	(98,616)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,977,766	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	170,394	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 170,394	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,148,160	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,139,747	1
2	Discounts and Allowances for all Levels	(63,662)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,076,085	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	223,271	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 223,271	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	22,585	12
13	Barber and Beauty Care	725	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	107,893	17
18	Sale of Supplies to Non-Patients	178,807	18
19	Laboratory	7,922	19
20	Radiology and X-Ray	1,971	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 319,903	23
	D. Non-Operating Revenue		
24	Contributions	310	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 310	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	7,599	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,599	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,627,168	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,024,684	31
32	Health Care	2,491,796	32
33	General Administration	1,094,410	33
	B. Capital Expense		
34	Ownership	727,181	34
	C. Ancillary Expense		
35	Special Cost Centers	16,320	35
36	Provider Participation Fee	102,383	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,456,774	40
41	**Income before Income Taxes (line 30 minus line 40)****	170,394	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 170,394	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.** **Extension Filed**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 45,344	$ 21.80	1
2	Assistant Director of Nursing	2,000	2,080	37,797	18.17	2
3	Registered Nurses	12,803	13,315	233,412	17.53	3
4	Licensed Practical Nurses	20,696	21,524	292,938	13.61	4
5	Nurse Aides & Orderlies	87,008	90,488	893,121	9.87	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,225	6,474	60,787	9.39	8
9	Activity Director					9
10	Activity Assistants	7,435	7,732	62,166	8.04	10
11	Social Service Workers	5,666	5,893	64,591	10.96	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	23,920	11.50	13
14	Head Cook	25,878	26,913	186,241	6.92	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,648	5,874	55,037	9.37	17
18	Housekeepers	28,806	29,958	202,817	6.77	18
19	Laundry	13,602	14,146	96,336	6.81	19
20	Administrator	2,884	2,964	149,536	50.45	20
21	Assistant Administrator					21
22	Other Administrative	6,745	6,745	129,923	19.26	22
23	Office Manager					23
24	Clerical	14,229	15,100	160,560	10.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) QA,CarePl,Inserv	6,240	6,526	117,633	18.03	33
34	TOTAL (lines 1 - 33)	249,865	259,892	$ 2,812,159 *	$ 10.82	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	381	$ 9,893	1-3	35
36	Medical Director	135	18,000	9-3	36
37	Medical Records Consultant	95	4,100	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	84	840	10-3	39
40	Physical Therapy Consultant	1,570	80,013	10a-3	40
41	Occupational Therapy Consultant	264	15,929	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	324	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	138	7,250	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,672	$ 136,349		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 280	10-3	50
51	Licensed Practical Nurses	2,250	70,562	10-3	51
52	Nurse Aides	13,703	229,270	10-3	52
53	TOTAL (lines 50 - 52)	15,961	$ 300,112		53

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debbie Cutright	Administrator	0	$ 69,973
Steve Wolf	Exec Admin	30	79,563
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 149,536

B. Administrative - Other

Description	Amount
Home Office Prorate	$ 99,464
TOTAL (agree to Schedule V, line 17, col. 3)	$ 99,464
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane,Morris & Hecksher	Legal	$ 1,824
Flynn & Guymon	Legal	75
Van Ostrand	Legal	2,116
Wessel & Pautsch	Legal	312
SAMAS	Legal	110
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 4,437

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,612
Unemployment Compensation Insurance	21,968
FICA Taxes	199,382
Employee Health Insurance	46,096
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	24,446
Home Office Payroll Taxes	30,672
TOTAL (agree to Schedule V, line 22, col.8)	$ 378,176

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	11,285
Health Care Worker Background Check	
(Indicate # of checks performed 118)	1,416
Home office Dues & Fees	703
Other Lic & Dues	3,240
Subscriptions & Comm Notices	4,908
Advertising,Pub Rel, Lobbying	30,042
Contr	638
IHCA Dues	6,790
Less: Public Relations Expense	(638)
Non-allowable advertising	(30,638)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,946

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	11,088
Home Office Seminar Cost	915
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,003

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Eldercare of Alton # 0023317 Report Period Beginning: 1/1/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Eldercare of Alton # 0023317 **Report Period Beginning:** 1/1/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $6790**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3-15y**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **939** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **102,383**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.